

Case Number:	CM14-0084174		
Date Assigned:	07/25/2014	Date of Injury:	03/14/2008
Decision Date:	09/24/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/06/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 64-year-old male who was reportedly injured on March 14, 2008. The mechanism of injury is not listed in the records reviewed. The most recent progress note on May 20, 2014, indicates that there are ongoing complaints of right shoulder pain and bilateral hand/wrist pain. Current medications include oxycontin, oxycodone, lyrica, naproxen, omega-3, calcium, vitamin B and glucosamine chondroitin. The physical examination demonstrated tenderness along the right shoulder bicipital groove and acromioclavicular joint. There was full range of motion of the right shoulder and decreased bicep and deltoid strength at 4 out of 5. The examination of the left hand wrist indicated dorsal wrist tenderness. Neurological assessment revealed decreased two-point discrimination at the radial side and ulnar side of both thumbs and index fingers. Examination the right hand wrist indicated moderate carpal tenderness. Diagnostic imaging studies were not reviewed during this visit. Previous treatment is unknown. A request was made for oxycontin and was not certified in the pre-authorization process on May 23, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Oxycontin 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75,78,92,97.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no documentation of improvement in their pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request for oxycontin is not medically necessary.